State of Minnesota **District Court**

County of	Judicial District:
	Court File Number:
	Case Type:

☐ In Re the Marriage of:

_____

_____

Petitioner

and

Affidavit in Support of Responsive Motion to Modify Medical Support ONLY

_____

Respondent

_____

Intervenor

STATE OF MINNESOTA)
) SS
COUNTY OF_____)
(County where Affidavit Signed)

I state that the following information is true and correct to the best of my knowledge.

1. My name is_____.

2. In this case, medical support is for:

Child's Name	**Date of Birth**	**Is there court -ordered parenting time?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

(Attach a page if more space is needed)

If you and the other parent have any other minor children together who are not part of this court case, write the children's names and dates of birth here:_____

_____

Reasons Why The Existing Support Order Should or Should Not Be Changed

3. *Choose one option*

☐ I do not want the current medical support order changed. There has not been a change of circumstances for me or the other parent, since the order was issued. (*If you want to comment on the other parent's statements about changes in finances or other circumstances, do that here*):

_____

_____

_____

_____

_____

_____

_____

If you need more space, attach a sheet of paper.

OR

☐ I ask the court to modify the current medical support order. I will provide proof to support my requests below. **I request a change in the current medical support order because of: (check all that apply)**

- ☐ Change in the availability of medical and/or dental insurance coverage for the joint child(ren). The parent currently ordered to provide coverage is ☐ me ☐ other party.
- ☐ Substantial change in the cost of medical and/or dental insurance coverage coverage for the joint child(ren).
- ☐ Change in eligibility for Medical Assistance for the child(ren) for ☐ me ☐ other party.
- ☐ Parent ordered to provide coverage is not/has not provided coverage for the joint child(ren).
- ☐ Tax dependency exemption is not ordered to be with the parent ordered to carry coverage.
- ☐ Tax dependency exemption was not addressed in the current order and the noncustodial parent is ordered to carry the coverage.

4. (*Answer #4 if you are asking for a change to the current support order*) I make the following other comments in support of my request for a change to the current medical support order: *(Explain the items you checked at #3. For example, why has the availability of medical and/or dental insurance changed? How much has the cost changed? Attach documents or bills that help to prove what you are saying.)*

_____

_____

_____

If you need more space, attach a sheet of paper.

5. a) The child(ren) currently have health care coverage as follows (this may be different than what is currently ordered):
☐ Minnesota Care
☐ Medical Assistance
☐ No coverage
☐ I provide coverage
☐ Other parent provides coverage
☐ Other:_____

b) Is the person actually providing the coverage, as stated above, the person ordered to provide the coverage? ☐ Yes ☐ NO

c) I want to change the way health care coverage is provided for the child(ren). *(Explain what you want changed, and why)*_____

_____

_____

d) Health care coverage is available for the child(ren) through my work or union:

☐YES ☐NO If Yes, answer the following:

i. Cost of monthly health care coverage for self: $ _____

ii. Cost of monthly health care coverage for dependents: $ _____

iii. Cost of monthly dental insurance for self (if separate coverage from health care coverage): $ _____

iv. Cost of monthly dental insurance for dependents (if separate coverage from health care coverage): $ _____

If coverage is not available through your work, have you checked on the cost of buying private insurance to cover the health needs of the child(ren)? ☐YES ☐NO
If yes, what is the cost? $_____per month.

6. I receive *(check only if it applies)*

☐ MinnesotaCare
☐ Medical Assistance

☐ General Assistance
☐ SSI

7. To the best of my knowledge, the other parent receives:

☐ MinnesotaCare
☐ Medical Assistance
☐ General Assistance
☐ SSI

I declare under penalty of perjury that everything I have stated in this document is true and correct. Minn. Stat. § 358.116.

Dated: _____

_____
Signature

Print Name: _____

Address: _____

City/State/Zip: _____

Telephone: (____) _____

E-mail address: _____